Reasonable nursing cost, limits, and grouping for representative sampling are described in 114.2 CMR 5.09 (see Appendix 1).

Representative Sampling. For the purposes of computing the ceiling for reasonable nursing costs, providers were grouped by three geographic regions referred to as Nursing Home Reimbursement Areas (NHRAs), as follows:

(a) NHRA 1 = HSA 1;
(b) NHRA 2 = HSA 2 and 5; and,
(c) NHRA 3 = HSA 3, 4, and 6

NHRAs are three distinct geographic areas designated by HSAs for the purpose of computing the limitation on reasonable nursing costs. The Commonwealth is divided into six (6) Health Service Areas (HSAs) by the state Department of Public Health. HSA1 is Western Mass; HSA2 is Central Mass (Worcester region); HSA3 is Northeastern Mass; HSA4 is Greater Boston area; HSA5 is Southeastern Mass, including Cape Cod; and HSA6 is the North Shore area beyond Boston.

Limitations. Allowable Nursing costs shall be limited to 110% of the Median claimed Base Year nursing costs incurred by a representative sample of facilities. All claimed Base Year nursing cost in excess of the facility's peer-group ceiling shall be excluded. Pediatric nursing facilities shall not be subject to the nursing cost limitations. The determination of reasonable nursing costs allowed in the calculation of prospective rates for nursing facilities, including limitations, is set forth in 114.2 CMR 5.09 (4) (see Appendix 1).

In calculating allowable nursing costs, the facility's average cost per management minute shall be determined by dividing the claimed 1993 nursing cost per diem by the facility's average management minutes score from the Case-Mix Data. To determine the ten case-mix adjusted nursing per diem amounts, the facility-specific mean minutes per case-mix category from the Case-Mix Data shall be multiplied by
the facility's allowable nursing cost per management minute. If the facility-specific mean minutes per case-mix category equals zero, the industry median minutes for that category shall be used. A copy of

the scale of minutes for the ten (10) Management Minute categories in effect beginning July 1, 1991 is attached as Appendix 2.

Calculation of Allowable Nursing Costs for rates effective January 1, 1996. The calculation of the allowable nursing costs shall be computed according to the criteria set forth above. The Cost Adjustment Factor set forth in Section II. B. 3. of this plan amendment shall be applied to the allowable nursing costs. The costs shall then be further increased by 2.52%.

5. Depreciation, Interest and Equity

The allowable basis for fixed assets, and the calculation of allowable depreciation, interest and equity are described in 114.2 CMR 5.10, 114.2 CMR 5.11 (Equity Allowance for Proprietary Providers), 114.2 CMR 5.12 (Interest Expense), 114.2 CMR 5.13 (Depreciation) and 114.2 CMR 5.14 (New Facilities and Major Additions) in Appendix 1.

D. Audits

Costs and expenses used to calculate the prospective rate of payment shall be established on the basis of a comprehensive desk audit. In addition, whenever possible, the Rate Setting Commission will also conduct on-site field audits to ensure the accuracy of claims for reimbursement and consistency in reporting. Any record not produced at the request of Rate Setting Commission during an audit shall be deemed not to have been maintained and therefore disallowed.

E. Rate Limitations

1. Medicare Upper Limit of Payment

No weighted average prospective rate of payment established under 114.2 CMR 5.00 et seq. (see Appendix 1) shall exceed the amount that can be reasonably estimated to be paid for these services under Medicare principles of reimbursement. An adjustment will be made only to the extent the costs are reasonable and attributable to the circumstances specified under the Medicare principles and separately identified and verified by the provider.

2. Private Rate Limitation

No prospective rate of payment established under 114.2 CMR 5.00 shall exceed the rate charged by the provider to private patients for the same or similar services and accommodations. The limitation shall not apply to that portion of prospective rates established for Patient Protector Receivers appointed pursuant to M.G.L. c. 111, §72M et seq. (see Appendix 6) which reimburses for the Receiver's compensation and bond as determined under 114.2 CMR 5.17(8) (see Appendix 1).

a. Methodology

The Rate Setting Commission in calculating the private rate limitation shall:

i. determine the weighted average Publicly-Aided patient rate for the Base Year and compare it to the average private rate for the same period, as reported in the cost report for the Base Year.

ii. If a facility's weighted average prospective rate for its Publicly-Aided Patients is greater than the average rate charged by the provider to private patients, the provider may produce justification for such lower rate for private patients before the limitation is applied. Such justification shall include quarterly Management Minute Questionnaires for all private patients. If the provider can classify the private patients into one of the ten case-mix categories, the rate limitation will be the prospective rate for Publicly-Aided Patients as established by the Rate Setting Commission for that case-mix category rather than the weighted average rate for all Publicly-Aided patients.

b. Failure to Meet the Rate Limitation

When a long-term care provider fails to satisfy the requirement for rates charged to private patients, the Rate Setting Commission shall multiply the difference between the weighted average rate for Publicly-Aided Patients and the average rate charged to private patients by the number of patient days for those discounted private patients to determine the aggregate difference.

F. Notice of Proposed Rate

At least ten (10) days prior to scheduled Rate Setting Commission action certifying a prospective rate for a provider, a notice of the proposed rates and a copy of adjustments to the provider's base-year costs shall be sent to the provider. A provider may comment in writing on the proposed rates and any adjustments during the period between notice and scheduled Rate Setting Commission action. If additional time is required to formulate a written comment, the provider may request in writing a postponement of scheduled Rate Setting Commission action. In the case of a preliminary prospective rate determined pursuant to 114.2 CMR 5.04(11) (see Appendix 1), the ten (10) day comment period provided for in this section shall not commence until the Rate Setting Commission issues notice of the audited prospective rates.

G. Retroactive Adjustments to the Prospective Rates

In general, the prospective rates shall not be adjusted retroactively. However, the Rate Setting Commission may retroactively adjust the prospective rates upwards or downwards under some circumstances. They include:

1. accrued but unpaid expenses (114.2 CMR 5.05(4)(m) (see Appendix 1);

2. errors in the cost reports as revealed by audit finding (114.2 CMR 5.04(5) (see Appendix 1);

3. mechanical errors (114.2 CMR 5.17(1) (see Appendix 1);

4. termination of receivership (114.2 CMR 5.17(8) (see Appendix 1);

5. administrative adjustments (114.2 CMR 5.15) (see Appendix 1); and,

6. look back provisions (114.2 CMR 5.14(3) (see Appendix 1).

H. Computation of Preliminary Prospective Rates

Where a desk audit for a facility has not been performed before the effective date of prospective rates determined under 114.2 CMR 5.04 (see Appendix 1), the Rate Setting Commission may establish preliminary prospective rates for such facility based on base-year reported costs. Such rates shall remain in effect until the desk audit has been completed and shall thereafter be
superseded by rates which reflect desk audit findings, if any. Rate Setting

Commission action on preliminary prospective rates taken under 114.2 CMR 5.04 shall not be subject to appeal under 114.2 CMR 5.16 (see Appendix 1).

I. Determination of Reasonable Capital Expenditure for Facilities Building in Urban Underbedded Areas

For the purposes of establishing rates of payment, special provisions, as defined in 114.2 CMR 5.10(6) (see Appendix 1), will be utilized to determine Maximum Capital Expenditure for facilities exempt from the Department of Public Health Determination of Need process pursuant to its "Guidelines for Determination of Need Exemptions for long Term Care Beds Constructed in Urban Underbedded Areas".

III. General Cost Principles

For rate setting purposes, a cost must satisfy, at a minimum, the following criteria:

(a) The cost is ordinary, necessary and directly related to the care of publicly-aided patients;
(b) the cost adheres to the prudent buyer concept;

(c) the cost is for goods or services actually provided in the nursing home; and,
(d) the cost effect of transactions that have the effect of circumventing these rules are not allowable under the principle that the substance of the transaction shall prevail over form.

Expenses allowed in the computation of casemix rates of payment to nursing facilities, and limitations and disallowances thereof are set forth in 114.2 CMR 5.05 (2) through 114.2 CMR 5.14 (4) (see Appendix 1).

A. Principles Governing Cost Splitting

Any cost which is split across two or more accounts on the cost report(s) shall be supported by adequate documentation. Adequate documentation for personnel costs that are split shall be defined as follows: complete and detailed time records such as time cards or sheets, recorded on an individual basis, and supporting the splitting of the personnel costs among the accounts; as well as work schedules and job descriptions. Each account impacted by such cost splitting shall be identified and the cost splitting fully explained in the Footnotes and Explanation schedule of the cost report. Cost splitting of certain accounts is prohibited as noted throughout these regulations.

B. Payments to Related Parties

Expenses otherwise allowable shall not be included for the purposed of determining per diem rates where such expenses are paid to a related party, ***as defined in 114.2 CMR 5.02 (attached as Appendix 1),*** unless the provider identifies any such related party and expenses attributable to it in the reports submitted and demonstrates that such expenses do not exceed the lower of the cost to the related party or price of comparable services, facilities or supplies that could be purchased elsewhere.

C. Services of Non-Paid Workers

The net value of services of non-paid persons occupying positions customarily held by paid employees who perform such services on a regular basis as non-paid members of religious or other organizations shall be allowable for reimbursement subject to the requirements set forth in subject to 114.2 CMR 5.05(3) (b) (see Appendix 1).

D. Non-Allowable Costs

Non-allowable costs for the calculation of prospective nursing facility rates include those listed at 114.2 CMR 5.05 (4) (see Appendix 1).

E. Costs of Direct Services and Supplies

Medical Supplies and services as described in 114.2 CMR 5.05(5)(a) (see Appendix 1) shall not be included in the calculation of rates. Where the inclusion of such costs are more efficient and practicable for the establishment of fair, reasonable and adequate rates all or a portion of such costs may be allowed, ***under contractual conditions***, for certified long-term care nursing units of acute and chronic care hospitals.

F. Accrued but Unpaid Expenses

When a provider fails to pay expenses which have been accrued at year end for more than one hundred twenty (120) days and which have been included in the prospective per diem rates, the Rate Setting Commission may adjust the prospective downward to reflect only those costs that have been paid, except for vacation and sick time accruals in accordance with 114.2 CMR 5.05(4)(m) (see Appendix 1).

G. Limitation on Rental and Leasehold Expenses

A nursing facility's reasonable rental and leasehold expenses for land, building and equipment shall be allowed, but limited to the lower of: average rental or ownership costs of comparable providers, or the reasonable and necessary costs of the provider and lessor which shall include interest, depreciation, real property taxes and property insurance. Proprietary lessors may be allowed a return on Average Equity Capital relative only to the nursing facility, if it would have been allowed had the provider owned the facility. Rental and leasehold expenses incurred by the

nursing facility for items which are not physically located in the nursing facility shall not be reimbursed as fixed and shall be covered by the Administrative and General Allowance. Providers who rent or lease incidental office equipment which is located at the facility shall have such rent allowed as a reasonable operating cost subject to the prudent Buyer Concept provided that such rental is necessary and contributes to provider efficiency.

H. Rent Based on Income.

Additional rental payments or charges based upon receipts or income shall not be considered as additional rental expense.

I. Employee Benefits.

The provider's contribution of Generally Available Employee Benefits shall be deemed an allowable cost if the benefits meets the requirements for a Generally Available Employee Benefit as set forth in 114.2 CMR 5.05 (8) (see Appendix 1).

J. Pension Plans

Reasonable and necessary expenses incurred by a provider relating to a pension plan shall be included as a Generally Available Employee Benefit subject to all the provisions of 114.2 CMR 5.00, including the reasonable cost limits set forth in 114.2 CMR 5.00. To be reimbursed, pension plans must provide for either fixed, determinable amount to be contributed by the employer on a regular basis or for a fixed, determinable benefit to be received by the employee at retirement. Pension plan costs also be subject to the provisions set forth in 114.2 CMR 5.05 (9) (see Appendix 1).

IV. New Facilities and Major Additions

A. New Facilities and Major Additions which become operational after July 1 of the rate year shall have their rates based upon the projected data as described in 114.2 CMR 5.14(1) (see Appendix 1). These rates will remain in effect to the end of the first rate year. The rates for the second rate year will be based on the same projected cost data, but shall be set based upon the ceilings and limitations in effect for the new rate year.

B. New Facilities and Major Additions which become operational less than six months prior to the beginning of a new rate year shall have their new rate

year prospective rates calculated from the projected data as described in 114.2 CMR 5.14(1) (see Appendix 1), using the ceilings and limitations in effect for the new rate year.

C. Capital Allowance for New Facilities and Major Additions. Facilities which open in 1996 or add a substantial capital expenditure, ***as defined in 114.2 CMR 5.15 (1)(a) (see Appendix 1,)*** or major addition in 1996 shall receive a capital allowance in lieu of all capital costs, including interest, depreciation, return on equity allowance, building insurance and real property taxes, except that the Capital Allowance shall not be applicable to the owner of an approved Determination of Need or a final plan approval dated prior to January 1, 1996 for improvements made or to be made pursuant to the Department of Public Health's regulation 105 CMR 150.017 (A) (see Appendix 7). If the owner of an approved Determination of Need or final plan approval transfers the rights under such approval after December 31, 1995, the Capital Allowance shall be applicable, unless a Notice of Intent to Acquire was filed with the Department of Public Health prior to December 31, 1995.

For rates effective January 1, 1996, the allowance shall be set at $5.61 per diem. However, transition period allowance rules apply for rates effective January 1, 1996. Any facility that has base year capital cost per diem that is greater than the allowance of $5.61 per diem, ***the capital allowance shall be the lower of $13.40 or $5.61 plus 75% of the difference between the facility's base year capital cost per diem and $5.61. Any facility that has base year capital cost per diem that is less than the allowance of $5.61 per diem, the capital allowance shall be the facility's capital cost per diem plus 30% of the difference between $5.61 and the facility's base year capital cost per diem.***

V. Administrative Adjustments to Prospective Rates

A nursing home with a prospective rate of payment may apply for discretionary administrative adjustment of the rate for any of the reasons, subject to conditions and limitations, specified in 114.2 CMR 5.15 (see Appendix 1). Upon receipt of such request, the Rate Setting Commission shall notify the Division of Medical Assistance of the provider's stated financial hardship. The Division of Medical Assistance may subsequently assess the need for the facility to remain as a participant in the Medicaid program should the request be denied and it may begin all necessary preparations for transferring publicly-aided patients.

VI. Appeals

A. Statutory Basis

Any provider aggrieved by a rate of payment established pursuant to 114.2 CMR 5.00 et seq. (see Appendix 1) may file an appeal with the Division of Administrative Law Appeals, established under M.G.L. c. 7, §4H (see Appendix 3), within thirty (30) calendar days of the filing of any such rate with the state secretary. Appeals hereunder shall be governed by the provisions of M.G.L. c. 6A, §36 (see Appendix 4).

B. Standard on Appeal

On appeal, the validity of any rate established for a provider shall be judged solely on the basis of its conformity with the principles governing the determination of rates contained in 114.2 CMR 5.00 (see Appendix 1).

C. Pending Appeal

The pendency of a proceeding or hearing may not be construed to prevent the Rate Setting Commission from redetermining a rate of payment for any reason the Rate Setting Commission may consider appropriate under M.G.L. c. 6A, §§31-46 (see Appendix 4), and the Rate Setting Commission shall have the right to request information pursuant to 114.2 CMR 5.03(6) and 5.04(5) not withstanding the pendency of any such proceeding or hearing. The Provider's rate as determined by the Rate Setting Commission under 114.2 CMR 5.00 et seq. (see Appendix 1) shall apply in the meantime.

VII. Special Provisions

A. Mechanical Errors

Where an error has been made in computing a provider's rate under 114.2 CMR 5.00 et seq. (see Appendix 1) and the error is the result of a purely mechanical error by the Rate Setting Commission, the Rate Setting Commission shall recompute and recertify a rate.

B. Rate for Innovative and Special Programs

The Division of Medical Assistance may contract for special and/or innovative programs to meet special needs of certain patients which are not ordinarily met by existing services in nursing facilities. Currently, these programs include programs for patients with traumatic brain injury, AIDS,

mental illness and medical illness (MIMI's), technologic dependency, ***and/or other conditions requiring heavy or unusual care not usually provided in nursing facilities.***

A provider who seeks to participate in an innovative and special program must contract with the Division of Medical Assistance to provide special care and services to distinct categories of patients designated by the Division of Medical Assistance. This is usually done through a Request for Proposals by the Division of Medical Assistance for special or innovative programs to address special needs of certain patients which are not ordinarily met by existing services in nursing facilities.

Reimbursement under the innovative and special programs may be calculated based on the added allowable actual costs and expenses which must be incurred (as determined by the Division of Medical Assistance) by a provider in connection with that program. However, it still must be consistent with the payment methodology established for long-term care facilities. The provider must verify that such items or services are furnished because of the special needs of the patients treated as contemplated in the contract with the Medical Assistance Program, and that such items or services are necessary in the efficient delivery of necessary health care. These costs will be added as an increment to the facility's rate in establishing a rate for an innovative and special program. In the event that the special program is located within a special unit, the remaining costs of the unit are to be integrated into the cost report (RSC-1) for the entire facility.

A facility that has recently converted from a facility providing non-acute hospital services to a facility providing nursing facility services may be reimbursed as a special program. In order to be considered as a special program, such a facility must agree to provide, or arrange and pay for, all Medicaid covered services, except hospital services, to all Medicaid recipients that are residents of the facility. The reimbursement to such facilities shall be a per diem rate which shall be the facility's regular case mix rates with an add-on which shall be based on the reasonable costs of providing the goods and services beyond those required to be provided by nursing facilities.

A provider whose resident population primarily and consistently consists of high-acuity high-nursing need residents such that the aggregate need of the entire population requires a staffing level significantly greater than a typical nursing facility may be reimbursed as a special program, in which case the

increment added to the facility's rate may apply to all residents of the facility and will be calculated based on allowable costs associated with the higher care needs of the patients. In order to be eligible for reimbursement under this paragraph, a nursing facility must meet each of the following criteria:

(1) (i) at least ninety percent (90%) of its residents must have Management Minute ("MM") scores that fall in either MM category 9 or 10 and at least seventy-five percent (75%) of its residents must have MM scores that fall in MM category 10; or (ii) the facility must be a former acute hospital that has undergone conversion to a nursing facility under the auspices of the Massachusetts Acute Hospital Conversion Board; and,

(2) the mean MM score for all residents of the facility in MM category 10 must be at least fifteen percent (15%) higher than the minimum score needed to quality for MM category 10; and,

(3) the facility must be a geriatric nursing facility.

C. Facilities that are Converting to Assisted Living Programs.

For facilities that are identified, in writing, by the Division of Medical Assistance for treatment under this provision, the Rate Setting Commission shall undertake any and all rate development and certification action as deemed necessary and appropriate after consultation with the Division of Medical Assistance.

D. (1) Information Bulletins

The Rate Setting Commission may, from time to time, issue information bulletins interpreting or clarifying provisions of 114.2 CMR 5.00 (see Appendix 1). Such bulletins shall be deemed to be incorporated in the provisions of 114.2 CMR 5.00 and shall be filed with the Massachusetts Secretary of State, shall be distributed to providers, and shall be accessible to the public at the Rate Setting Commission's offices during Rate Setting Commission business hours.

(2) Publicly Aided Patients in Long Term Care Facilities in States Other than Massachusetts

When a publicly aided patient is placed in a long term care facility in

a state other than Massachusetts, the Division of Medical Assistance shall pay the per diem rates paid by the state in which the facility is located.

E. Reimbursement of a Receiver Appointed Under M.G.L. c.111 §72M et seq. (see Appendix 6)

The prospective rates of a facility will be increased by an appropriate per diem amount to provide reasonable compensation to a receiver. Such reimbursement is described in 114.2 CMR ***5.17***(8) (Appendix 1).

F. Use and Occupancy Allowance for Certain Non-Profit Providers

The per diem rates of non-profit providers, shall reflect the cost of use and occupancy of net allowable fixed assets. Such use and occupancy per diem allowance shall be calculated by the formula and method expressed in 114.2 CMR 5.11 (see Appendix 1) and divided by three. This allowance will be added to the calculation of per diem rates of otherwise eligible non-profit providers provided that they have maintained public occupancy of at least seventy percent (70%). This section will only be applied to those facilities which meet the criteria set forth in 114.2 CMR 5.19 (2) (see Appendix 1).

G. Review and Approval of Rates and Rate Methodology By The Division of Medical Assistance

Pursuant to M.G.L.c 118E, §13 (see Appendix 5) the Division of Medical Assistance shall review and approve or disapprove, any change in rates or in rate methodology proposed by the Rate Setting Commission. The Division of Medical Assistance shall review such proposed rate changes for consistency with state policy and federal requirements, and with the available funding authorized in the final budget for each fiscal year prior to certification of such rates by the Rate Setting Commission; provided that, the Division of Medical Assistance shall not disapprove a rate increase solely based on the availability of funding if the Federal Health Care Finance Administration provides written documentation that federal reimbursement would be denied as a result of said disapproval and said documentation is submitted to the Massachusetts House and Senate Committees on Ways and Means. The Division of Medical Assistance shall, whenever it disapproves a rate increase, submit the reasons for disapproval to the Rate Setting Commission together with such recommendations for changes. Such disapproval and recommendations for changes, if any, shall be submitted to the Rate Setting Commission after

the Division of Medical Assistance is notified that the Rate Setting Commission intends to propose a rate increase for any class of provider under Title XIX but in no event later than the date of the public hearing held by the Rate Setting Commission regarding such rate change; provided that no rates shall take effect without the approval of the Division of Medical Assistance. The Rate Setting Commission and the Division of Medical Assistance shall provide documentation on the reasons for increases in any class of approved rates that exceed the medical component of the consumer price index to the Massachusetts House and Senate Committees on Ways and Means. The Rate Setting Commission shall supply the Division of Medical Assistance with all statistical information necessary to carry out the Division's review responsibilities under this Section. Not withstanding the foregoing, said Division of Medical Assistance shall not review, approve, or disapprove any such rate set pursuant to Chapter Twenty-Three of the Massachusetts Acts of Nineteen Hundred and Eighty-Eight.

If projected payments from rates necessary to conform to applicable requirements of title XIX are estimated by the Division of Medical Assistance to exceed the amount of funding appropriated for such purpose in the budget for such fiscal year, the Division of Medical Assistance and the Rate Setting Commission shall jointly prepare and submit to the Governor a proposal for the minimum amount of supplemental funding necessary to satisfy the requirements of the State Plan developed by the Division of Medical Assistance under Title XIX of the Federal Social Security Act.

H. Legislative Mandate for Rate Relief

A nursing home (i) with rate of public utilization, consisting of Medicare, Medicaid and Commission for the Blind patients, of ninety percent or more, (ii) located in the service area of a federally designated sole community hospital, and (iii) with more than 10% of its variable costs and nursing costs disallowed by the Rate Setting Commission pursuant to 114.2 CMR 5.00 or any successor regulation, shall have all of its variable costs and nursing costs recognized by the Rate Setting Commission and its Medicaid rate adjusted accordingly. The Rate Setting Commission shall adjust the prospective rates for any such nursing home that meet the aforementioned criteria for the rates that were effective January 1, 1994 and for each succeeding rate year that such nursing homes comply with aforementioned criteria. The amount of variable costs and nursing costs recognized as allowable by the Rate Setting Commission for any rate for a nursing home

shall be limited to an amount that will not increase costs to the Medical Assistance program in an amount greater that three hundred thousand dollars.

Any nursing home transferred to a new owner in 1992 shall be entitled to elect to have the costs reported by the prior owner for calendar year 1991 as base year costs for the determination of prospective rates established by the Rate Setting Commission under 114.2 CMR 5.00 for rates in effect in 1994 and to use said base year costs for rates any subsequent rate year for which the Rate Setting Commission uses 1992 as a base year. The Rate Setting Commission shall trend said costs forward for inflation using a cost adjustment factor of nine and fifty-seven hundredths percent (9.57%). The Rate Setting Commission shall determine allowable nursing per diem rates by utilizing management minutes by patient by month for all months of the base year. To be eligible to make such an election, any such nursing home transferred in 1992 shall further demonstrate (i) a 1992 public occupancy rate including Medicaid, Medicare and Commission for the Blind patients, in excess for ninety percent (ii) a 1992 occupancy rate in excess of ninety-seven percent (iii) a location within the catchment area of a municipal acute care hospital; and (iv) financing with a section 504 loan, so-called, from the United States Small Business Administration.

Any nursing facility that meets either the standards set forth in (a) or (b) below shall have its total acquisition costs allowed as the allowable basis of fixed assets, notwithstanding any limits on the same that appear elsewhere in this State Plan, when the Division of Medical Assistance calculates the facility's reimbursement rates.

(a) 1. the owner purchased the nursing home on or after January 1, 1987;

2. the owner has received a determination letter from the Internal Revenue Service that it is an organization described in section 501(c)(3) of the Internal Revenue Code of 1986;

3. the owner (i) owns a nonprofit hospital (the "Hospital") located within the Commonwealth of Massachusetts which is licensed by the Department of Public Health or (ii) is a nonprofit organization affiliated with a nonprofit hospital which is organized and operated for the benefit of, to perform one or more functions of, or to carry out one or more of the purposes

of the nonprofit hospital it is affiliated with, including operation of freestanding nursing homes licensed by the Department of Public Health;

4. the owner's patient population is, on average, not less than eighty-five percent (85%) Medicaid recipients;

5. the Hospital has, on average, not less than eighty percent (80%) occupancy of medical or surgical beds;

6. when the owner purchased the nursing facility (i) the change of ownership did not occur between a person or organization which is associated or affiliated with or has control of or is controlled by the owner or is related to the owner or any director, trustee, partner, shareholder or administrator of the owner by common ownership or control or in a manner specified in section 267(b) and (c) of the Internal Revenue Code of 1986; (ii) the change of ownership was made for reasonable consideration; (iii) the change in ownership was a bona fide transfer of all powers and indicia of ownership and (iv) the change of ownership manifested an intent to sell the assets of the facility rather than implement a method of financing, or refinancing:

or

(b) 1. the owner acquired the nursing facility from an acute care hospital to operate the facility pursuant to relief granted to the acute care hospital by the acute care hospital conversion board pursuant to M.G.L. c.6A, §101;

2. the acute care hospital conversion board approved the owner's acquisition costs of the facility; and,

3. on average, no less than eight-five percent (85%) of the nursing facility's patient population are Medicaid recipients.

APPENDIX 2

CASEMIX MANAGEMENT MINUTES CATEGORIES

MANAGEMENT MINUTES CATEGORIES	RANGE OF MINUTES
H	0 - 65
J	65.1 - 85.0
K	85.1 - 110.0
L	110.1 - 140.0
M	140.1 - 170.0
N	170.1 - 200.0
P	200.1 - 225.0
R	225.1 - 245.0
S	245.1 - 270.0
T	270.1 +